Alliance Retina

Kim-Binh Mai, MD
Vitreoretinal Surgery and Diseases

PATIENT INFORMATION

Patient's first and last name:			Marital Status:		
Former maiden name:			Birth Date:	Age:	Gender: ☐ M ☐ F
Address (Street Name, City, Zip Code):					
Social Security No.:	Home Phone:		Cell Phone:		
Occupation:	Employer:		Work Phone:		
Email address:					

Race: (required by federal HIPAA regulations)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Black or African American
- ☐ Hispanic
- ☐ Other
- ☐ Unknown

IN CASE OF EMERGENCY

Emergency contact's full name:	Relationship to patient:	Cell Phone:	Work Phone:

PREFERRED PHARMACY

Name:	Phone:
Address:	Fax:

PRIMARY CARE PHYSICIAN

Name:	City:	Phone:
Address:		Fax:

OPTOMETRIST

Name:	City:	Phone:
Address:		Fax:

REFERRING PHYSICIAN

Name:	City:	Phone:

PRIMARY INSURANCE INFORMATION		
(please bring your insurance card(s) to your appointment and give it to the receiptionist)		
Primary Insurance Company:	Effective Date:	
Subscriber's Full Name:	Birth Date:	
Subscriber's SSN:	Patient's relationship to Subscriber:	
Group No.:	Policy No.:	Copay: $

SECONDARY INSURANCE INFORMATION		
Secondary Insurance Company:	Effective Date:	
Subscriber's Full Name:	Birth Date:	
Subscriber's SSN:	Patient's relationship to Subscriber:	
Group No.:	Policy No.:	Copay: $

WORKERS' COMPENSATION INFORMATION (complete only if injured at work)	
Employer at time of accident:	Date of injury:
Address:	Phone:
Insurance Company:	Phone:
Insurance Company Address:	
Claim Number:	Name of Adjustor:

Alliance Retina

KIM-BINH MAI, MD
VITREORETINAL SURGERY AND DISEASES

Patient's full name: **Date:**

MEDICAL HISTORY QUESTIONNAIRE

The Health Care Financing Administration requires we obtain the following information from you to be in compliance with their patient history guidelines for billing consultation services. If you have any questions regarding this form or need assistance, please let our staff know.

What symptoms or complaints do you have with your vision (please be specific, including dates)?

List all major illnesses and injuries that you have had in the past:

List any surgeries (including on your eyes) that you have had in the past:

List any medications (including any eye medications) that you take:

List any allergies you have (including medication allergies):

Do you presently have any problems with the following areas?

Integument (skin)	☐ YES	☐ No	☐ YES	☐ No	Neurological
Ears, Nose, Mouth, Throat	☐ YES	☐ No	☐ YES	☐ No	Lymph Nodes
Respiratory (lungs)	☐ YES	☐ No	☐ YES	☐ No	Hematopoietic (blood)
Cardiovascular (heart)	☐ YES	☐ No	☐ YES	☐ No	Allergic / Immunologic
Gastrointestinal (stomach)	☐ YES	☐ No	☐ YES	☐ No	Genitourinary
Bones, Joints, Muscles	☐ YES	☐ No			

Do you drink alcohol? ☐ YES ☐ No

Do you smoke? ☐ YES ☐ No

Are you taking blood thinners? ☐ YES ☐ No If yes, what are you taking? _______________

Do you think you may have been exposed to HIV? ☐ YES ☐ No

____

Patient/Guardian Signature